the conditions for the expedited appeals process set forth in § 405.718.

[62 FR 25852, May 12, 1997]

§ 405.732 Review of national coverage decisions (NCDs).

(a) *General.* (1) HCFA makes NCDs either granting, limiting, or excluding Medicare coverage for a specific medical service, procedure or device. NCDs are made under section 1862(a)(1) of the Act or other applicable provisions of the Act. An NCD is binding on all Medicare carriers, fiscal intermediaries, PROs, HMOs, CMPs, and HCPPs when published in HCFA program manuals or the FEDERAL REGISTER.

(2) Under section 1869(b)(3) of the Act, only NCDs made under section 1862(a)(1) of the Act are subject to the conditions of paragraphs (b) through (d) of this section.

(b) *Review by ALJ.* (1) An ALJ may not disregard, set aside, or otherwise review an NCD.

(2) An ALJ may review the facts of a particular case to determine whether an NCD applies to a specific claim for benefits and, if so, whether the NCD has been applied correctly to the claim.

(c) *Review by Court.* (1) A court's review of an NCD is limited to whether the record is incomplete or otherwise lacks adequate information to support the validity of the decision, unless the case has been remanded to the Secretary to supplement the record regarding the NCD. The court may not invalidate an NCD except upon review of the supplemented record.

(2) A Federal court may not hold unlawful or set aside an NCD because it was not issued in accordance with the notice and comment procedures of the Administrative Procedure Act (5 U.S.C. 553) or section 1871(b) of the Act.

(d) *Remands*—(1) *Secretary's action.* When a court remands an NCD matter to the Secretary because the record in support of the NCD is incomplete or otherwise lacks adequate information, the Secretary remands the case to HCFA in order to supplement the record.

(2) *Remand to HCFA.* HCFA supplements the record with new or updated evidence, including additional information from other sources, and may issue a revised NCD.

(3) *Final Actions.* (i) The proceedings to supplement the record are expedited.

(ii) When HCFA does not issue a revised NCD, it returns the supplemented record to the court for review.

(iii) When HCFA issues a revised NCD, it forwards the case to an ALJ who issues a new decision applying the revised NCD to the facts of the claim(s) under consideration. The ALJ's decision is subject to DAB review and, ultimately, judicial review.

[62 FR 25852, May 12, 1997]

§ 405.740 Principles for determining the amount in controversy.

(a) *Individual appellants.* For the purpose of determining whether an individual appellant meets the minimum amount in controversy needed for a hearing ($100), the following rules apply:

(1) The amount in controversy is computed as the actual amount charged the individual for the items and services in question, less any amount for which payment has been made by the intermediary and less any deductible and coinsurance amounts applicable in the particular case.

(2) A single beneficiary may aggregate claims from two or more providers to meet the $100 hearing threshold and a single provider may aggregate claims for services provided to one or more beneficiaries to meet the $100 hearing threshold.

(3) In either of the circumstances specified in paragraph (a)(2) of this section, two or more claims may be aggregated by an individual appellant only if the claims have previously been reconsidered and a request for hearing has been made within 60 days after receipt of the reconsideration determination(s).

(4) When requesting a hearing, the appellant must specify in his or her appeal request the specific claims to be aggregated.

(b) *Two or more appellants.* As specified below, under section 1869(b)(2) of the Act, two or more appellants may aggregate their claims together to meet the minimum amount in controversy needed for a hearing ($100).

The right to aggregate under this statutory provision applies to claims for items and services furnished on or after January 1, 1987.

(1) The aggregate amount in controversy is computed as the actual amount charged the individual(s) for the items and services in question, less any amount for which payment has been made by the intermediary and less any deductible and coinsurance amounts applicable in the particular case.

(2) In determining the amount in controversy, two or more appellants may aggregate their claims together under the following circumstances:

(i) Two or more beneficiaries may combine claims representing services from the same or different provider(s) if the claims involve common issues of law and fact;

(ii) Two or more providers may combine their claims if the claims involve the delivery of similar or related services to the same beneficiary; or

(iii) Two or more providers may combine their claims if the claims involve common issues of law and fact with respect to services furnished to two or more beneficiaries.

(iv) In any of the circumstances specified in paragraphs (b)(2)(i) through (b)(2)(iii) of this section, the claims may be aggregated only if the claims have previously been reconsidered and a request for hearing has been made within 60 days after receipt of the reconsideration determination(s). Moreover, in the request for hearing, the appellants must specify the claims that they seek to aggregate.

(c) The determination as to whether the amount in controversy is $100 or more is made by the administrative law judge (ALJ).

(d) In determining the amount in controversy under paragraph (b) of this section, the ALJ also makes the determination as to what constitutes ''similar or related services'' or ''common issues of law and fact.''

(e) When a civil action is filed by either an individual appellant or two or more appellants, the Secretary may assert that the aggregation principles contained in this subpart may be applied to determine the amount in controversy for judicial review ($1000).

(f) Notwithstanding the provisions of paragraphs (a)(1) and (b)(1) of this section, when payment is made for certain excluded services under §411.400 of this chapter or the liability of the beneficiary for those services is limited under §411.402 of this chapter, the amount in controversy is computed as the amount that would have been charged the beneficiary for the items or services in question, less any deductible and coinsurance amounts applicable in the particular case, had such expenses not been paid pursuant to §411.400 of this chapter or had such liability not been limited pursuant to §411.402 of this chapter.

(g) Under this subpart, an appellant may not combine part A and part B claims together to meet the requisite amount in controversy for a hearing. HMO, CMP and HCPP appellants under part 417 of this chapter may combine part A and part B claims together to meet the requisite amounts in controversy for a hearing.

[59 FR 12181, Mar. 16, 1994]

§ 405.745 Amount in controversy ascertained after reconsideration.

For the purpose of determining whether a party to a reconsidered determination is entitled to a hearing, the amount in controversey after the reconsideration action rather than the amount in controversy initially at issue shall be controlling.

[40 FR 1026, Jan. 6, 1975. Redesignated at 42 FR 52826, Sept. 30, 1977]

§ 405.747 Dismissal of request for hearing; amount in controversy less than $100.

The ALJ shall, without holding a hearing, dismiss the request for hearing if the request for hearing plainly shows that less than $100 is in controversy. If a hearing is held and the ALJ finds that the amount in controversy is less than $100, the ALJ shall dismiss the request for hearing and will not rule on the substantive issues involved in the appeal.

[37 FR 5814, Mar. 23, 1972. Redesignated at 42 FR 52826, Sept. 30, 1977, as amended at 62 FR 25855, May 12, 1997]